STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004773	A. BUILDING: _____ B. WING _____	06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON COUNTY HOSPITAL	1141 HOSPITAL DR NW CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS HFAP Surveyor: 34586 Facility Number: 004773 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey June 17-18/ 2014 Date of ISDH off site review - January 16, 2015 Reviewer/Surveyor --Kerry Sawin RN, PHNS Based on review of the June 17-18/2014 HFAP Accreditation Survey Report, it has been determined that Harrison County Hospital meets the requirements for Hospital Licensure in Indiana for 2014.	S 000		